MULTICULTURAL HEALTH CARE REQUIRES ADJUSTMENTS BY DOCTORS AND PATIENTS

Janice Hamilton

In Brief • En bref

Canada has become a multicultural society, and more physicians have patients who are immigrants or refugees from the Third World. While doctors are aware of the need for culturally sensitive health care, there is still room for improving the delivery of medical treatment to those of other cultures. Janice Hamilton spoke with physicians who have multicultural practices to get an idea of the challenges they have faced and the problems they have solved.

Le Canada est devenu une société multiculturelle. Davantage de médecins ont maintenant des patients immigrants ou réfugiés du Tiers Monde. Les médecins sont conscients de la nécessité de tenir compte des aspects culturels dans les soins médicaux, mais il y a encore place à l'amélioration à ce chapitre. Janice Hamilton s'est entretenue avec des médecins qui ont une pratique multiculturelle afin d'avoir une idée des défis auxquels ils ont fait face et des problèmes qu'ils ont réglés.

Staff in an outpatient clinic at the Montreal Children's Hospital (MCH) were concerned. Their young patient, a recent immigrant from Asia, did not seem to be improving. They suspected the parents were not following the treatment program and were frustrated by their inability to isolate the mother in order to teach her when the family arrived for appointments.

Eventually they called in a resource person, who explained that it was vital to enlist the support of the entire family, including the father and grandmother. "The idea was not to isolate the mother, but to make sure that everyone understood and agreed with the treatment program," says Heather Clark, director of the MCH Multiculturalism Office, which was established in 1986 to help the hospital adapt to changing times.

Canada is an increasingly multicultural society. In the 1991 Census, approximately one-third of Canadians identified themselves as having a background other than English or French. Statistics Canada reported that about 13% of Canadians had a mother tongue other than English or French, a proportion that is considerably higher in cities such as Toronto and Vancouver.

Efforts to provide culturally appropriate health care are being made in hospitals, clinics and physicians' offices across the country. In particular, family physicians are becoming more familiar with the cross-cultural dimension of many clinical situations because they are often the first contact new immigrants have with the health care system.

Although "culturally sensitive health care" is becoming a politically correct catchphrase, delivery is far from perfect. A 1995 study of recent immigrants to Saskatoon showed that some patients turn to traditional medicine if they find prescribed medications ineffective. Some reported communication problems and defined good doctors as the ones who listened, bad doctors as the ones who did not.

Cross-cultural communication can be difficult for both doctor and patient, says Margaret Lock, a professor in the departments of Anthropology and Social Studies in Medicine at McGill University. Both may be frustrated and perplexed about why great importance is attributed to certain symptoms and feelings, while others go unrecognized or ignored.

Lock says some providers would love to have a neat list — Guatemalans do this, Tamils do that — but warns that this type of stereotyping is not a solution. "We no longer have discrete cultures in different parts of the world. There is so much exchange that these kinds of differences get broken down." There are also huge intergenerational differences between young people brought up in North America and their immigrant parents. Socioeconomic factors add another dimension, and the health concerns of

Janice Hamilton is a freelance writer living in Montreal.

some immigrant and refugee groups may have as much to do with poverty as with culture.

Dr. Ralph Masi, a family physician in Downsview, Ont., and founding president of the Canadian Council on Multicultural Health, emphasizes the need to establish good relationships with patients from different cultural backgrounds. "The initial visit may take longer, but it is money in the bank if you can establish a relationship. Nine out of 10 times, subsequent visits will be much easier."

In a series of articles on multicultural health care in *Canadian Family Physician* in 1988–89, Masi suggested that awareness of cultural aspects of health can improve the relationship between doctor and patient, as well as patient compliance. If the patient understands and agrees with the treatment, and the physician understands the patient's views and ensures that the treatment is appropriate, the outcome will be better. For example, recommending that an elderly Italian man refrain from drinking wine, which may be an integral part of his diet and social life, may not be culturally appropriate treatment.

"It also makes medicine more fun because you're not always battling your patients," Masi said in an interview. "Cross-cultural communication follows the basic patterns of good communication."

However it's not easy to open such a dialogue, says Lock, both because of time pressures and because many doctors have not been trained to listen carefully. Even the first step — winning the patient's confidence — may be difficult because there is a cultural variation in attitudes toward physicians; many groups assume the doctor knows best and don't expect to be asked their opinions.

People from some backgrounds consider it impolite or inappropriate to ask questions or admit they don't understand. A physician can help by asking patients to explain what they will do when they leave the office. Who will take the pills? When?

Clark points out that some patients don't realize that antibiotics are only for the person who is sick, and should not be taken by all family members; others may be accustomed to taking herbal remedies that don't require precise dosages.

A first step in cross-cultural communication is for caregivers to realize that they have their own biases. In an article in *Health and cultures: exploring the relationships* (1993, Mosaic Press, Oakville, Ont.) Lock notes: "Self-reflection is more difficult than the recognition that others are strange and different, but it is essential to ethnically sensitive health care. As one medical student from Trinidad put it: 'It is as though some of us have culture, but the rest of you think you are beyond all that.' "

We are socialized to understand our bodies in culturally defined ways, says Lock. Furthermore, when physicians are trained in basic sciences like biochemistry and anatomy, they assume human bodies are the same and make standardized assessments; sometimes the individual patient, as a person, is lost in that approach.

There are other cultural dimensions to health, disease and treatment. In the Western approach, bodily functions involve organs and cells and there is a linear relationship between germs and disease. But patients may attribute illness to different causes. Many Asians believe in balancing yin and yang for health, with illness resulting from an imbalance between the two. Hispanic communities may believe there is a balance between "hot" and "cold" elements, and that these symbolic properties are present in practices, food, diseases and medications.

Dr. Alice Chan-Yip, a Montreal pediatrician, says she must be sensitive to these beliefs in her practice, which has patients from different cultures. "If you tell parents their beliefs are rubbish and just to take this medicine, they will leave your office with doubts about what you are saying. I ask them what yin-yang means, and often they don't know what it means. Then I say that yin-yang is a traditional belief which scientifically cannot be explained. I give them my explanation of the biological and psychological process of symptoms and explain, for example, how gastrointestinal problems can often be resolved by good nutritional practices."

There are also religious, spiritual and supernatural dimensions to health and illness. A Roman Catholic might pray for a fast recovery. One who believes that spirits or supernatural elements are involved in illness may turn to rituals to placate or solicit help from spirits, God or other deities. "Most people don't think twice about someone going to church to pray when they're ill," comments Masi. "But voodoo with a candle? Let's get rid of value statements. I must respect both equally."

When examining patients, physicians should consider biological variations between different ethnic groups, says Masi. Standard North American height and weight charts will not be applicable to children of some ethnic backgrounds. Metabolism also may vary; studies indicate that Southeast Asian populations metabolize antidepressants at a different rate than others, for instance.

Some disorders are more prevalent in certain populations; hypertension is a major health concern in the American black community, and there is a high risk of cervical cancer in Aboriginal populations. Chan-Yip suggests that physicians who deal frequently with members of one ethnic community can not only identify health problems that are prevalent in that group, but also ask why. In the 1980s she studied the low rate of breast-feeding in Montreal's Chinese community and the causes of iron deficiency in these babies.

Traditional advice can lead to problems. Lactose intolerance, for in-

stance, is very common among American blacks and Asians. Clark says well-meaning health care providers and child-care workers frequently don't realize this and encourage these children to drink milk. Lactose intolerance or cultural restrictions on milk may also create unexpected difficulties if someone tells a patient that taking barium is like drinking milk. "You have to make sure the thing you are comparing to is within the patient's experience," she notes.

Cultural aspects of illness-related behaviour can influence physicians' perceptions. A study done in New York in the 1960s showed that hospital staff treated patients with pain complaints differently, depending on their cultural group. Some were described as "taking their pain well" and others were seen as "alarmist." It is similar today, Masi notes. Patients who are very stoic in the face of pain risk being undermedicated, while those who tend to be dramatic and complain more about their symptoms may be given too much medication.

Sometimes language difficulties cause misunderstanding or misdiagnosis. A Jamaican may refer to a "weak heart" when what she really feels is panic. And for new immigrants whose first language is neither English nor French, lack of access to interpretation services can be a problem. Hospitals in urban settings may have access to interpreters, but in smaller communities relatives or others may be asked to interpret, and confidentiality becomes a concern.

"If there is a small Somali community in town, and you bring in a Somali interpreter, you might facilitate communication, but you might also block it," warns Clark. There may be political divisions within the community, or the patient may simply not want to divulge his health or personal problems. Clark recommends trying to ask the patient whether an interpreter is needed, and who the patient wants.

She says doctors should not confuse lack of knowledge of English with lack of education. The immigrant parent who brings a child to emergency may have practised medicine before coming to Canada.

Clark recommends the physician try early in the relationship to assess the patient's knowledge of health care and nutrition, and of Canadian health care services. "In some Eastern European countries, the general practitioner is the person who sends you to the specialists," she says. "The patient may believe the family physician does not have much expertise or is standing in the way of getting to the 'real doctors.' "

The hospital may also have a different role in other countries. Some parents become frightened when doctor wants to admit a child to the MCH for tests or observation. It often turns out that, in the country of origin, hospitalization means the patient is at death's door.

Clark also recalls a Haitian-born physician who had many patients from Haiti. One day a new patient, whose appointment had been scheduled for 9:30 am, arrived at 6 pm; she thought that, like in Haiti, she could just show up some time on the day of her appointment.

Initial meetings are a good opportunity to explain what Canadian family physicians do and how patients are expected to keep appointments. The physician can ask whether there are differences between the way health care providers work here and the way things are done in the patient's country of origin.

Finally, says Masi, cross-cultural health care doesn't mean the physician has to accept everything the patient does or believes. For example, he feels strongly about spousal abuse and refuses to accept it. He will advise patients that female circumcision is illegal in this country. He warns some patients that their way of disciplining children may cause problems. Others are told that cupping — a practice in which a hot cup is put on the skin to draw out bad spirits — leaves bruises that may be misinterpreted. Physicians who disagree with patients should make their patients aware without getting angry, he advises.

For Chan-Yip, the basis of cross-cultural health care is what she calls "bilateral education: you learn about your patient's cultural concepts, the family's structure, lifestyle and practices. Then you offer a sensitive, culturally specific explanation." For physicians, multicultural aspects of medical practice could be regarded not as an additional difficulty but as another opportunity to learn. ■

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